Printed: 06/11/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER				OULD BE COMPLETION
		175295		B. WING		
	OVIDER OR SUPPLIER		STREET ADDRE			
DESEREI	HEALTH AND REHA	AB AT SMITH CENTER		ST ST #369 ENTER, KS		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FU R LSC IDENTIFYING INFORMATI	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 000	INITIAL COMMENT	S		F 000		
	The following citations represent the findings of complaint investigation #75154.		of			
	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)			F 157		
	consult with the resicknown, notify the resicknown, notify the resicular or an interested farm accident involving the injury and has the printervention; a significantly, or deterioration in health status in either life the clinical complication significantly (i.e., a rexisting form of treat consequences, or to treatment); or a decident and interest of the consequences.	diately inform the resident dent's physician; and if sident's legal representati illy member when there is the resident which results it otential for requiring physiciant change in the resident psychosocial status (i.e., th, mental, or psychosocial reatening conditions or s); a need to alter treatmented to discontinue and the the theorem of the theo	ive s an in cician ent's a al			
	and, if known, the re or interested family in change in room or ro specified in §483.15 resident rights under	o promptly notify the residesident's legal representate member when there is a commate assignment as 5(e)(2); or a change in a Federal or State law or fied in paragraph (b)(1) or	tive			
	the address and pho	ord and periodically upda one number of the resider or interested family mem	nt's			
		s not met as evidenced by				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			(X3) DATE SUF		
		175295		B. WING			C I/ 2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE	· ·	
DESERET	HEALTH AND REHA	B AT SMITH CENTER		ST ST #369 CENTER, KS			
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F 157	facility failed to prompregarding a burn to Rabove the elbow. Findings included: Resident #1's sign 5/1/14-5/30/14, indicating skin and tissues beneopen wound on his/he (inflammation of the standard of vision) and vascular describing problems vigudgment, memory are caused by brain dama flow to your brain). The 4/23/14 quarterly 3.0 assessment indicated extensive assistance Daily Living and had a cognition with a (BIMS Status score of 8. The had impairment on his side and impairment of lower extremities. The 4/23/14 care plandard question unrealistic of to ensure the residen related to poor decisiterm memory. The cast to monitor independer	sidents. Based on eview and interview the poly notify the physician desident #1's right upper and physician orders, detected the resident had a (a bacterial infection or eath the skins) on the lefer buttock, dermatitis skin), macular degeneralition in which the centraleteriorates and causes or dementia (a general towith reasoning, planning and other thought processage from impaired blook (MDS) Minimum Data ted the resident require with (ADLs) Activities of	ated f the g, an ation al lack erm g, ses d Set d f ental sident n one and injury ort taff	F 157			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURY COMPLETE	
		175295		B. WING		06/11	/ 2014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE	I	
DESERET	THEALTH AND REHA	B AT SMITH CENTER		ST ST #369 ENTER, KS			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	II.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 157	space heater in the recomplaints of being of the weekly wound rerevealed the following On 4/25/14 the resider long by 3 cm wide bublistered skin on the labove his/her elbow. On 5/4/14 the resider long by 3 cm wide bublistered skin on the labove his/her elbow. On 5/9/14 the resider that remained the sar On 5/16/14 the reside back of his/her right a 2 small, 1 cm, open a surrounding the open. On 5/23/14 the burn after acquiring the burn afte	esident's room due to hisold. coord for the resident g: ent had no documentation thad a 6 (cm) centime rin area, with redness a back of his/her right arm and thad a "superficial bur me size as above. ent had a burn area to the right arm above his/her elbowareas with pink skin areas. area was healed. (19 days) M, nurse's note indicate the nurse the resident his/her right. The note indicated the esident and the area had e red area measuring 6 he note indicated the nal heater a few inches he nurse removed the had, nurse's note indicated.	on in ter nd n" ne y with ays ed an ad a arm d a cm from eater ed fter urse)	F 157			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		175295		B. WING		C 06/11/2014
NAME OF PE	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE	•
DESERE	THEALTH AND REHA	AB AT SMITH CENTER		ST ST #369 ENTER, KS		
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F 157	the wound on the bar measured 9 cm long in size from 6 cm to The 5/4/14 at 1:30 Programmer of the size from 6 cm to The 5/4/14 at 1:30 Programmer of the size from 6 cm to practitioner to adminused to treat infection (mg) milligram, three and to debride (to repromote infection and wash with soap and Vaseline dressing, a or 4 days if the area Review of the medic documentation the sintervention to the realization of the sintervention to the realization of the sintervention of	ick of the resident's right by 3 cm wide. (an incre 9 cm long.) I'M, nurse's note indicate refer from the nurse inster Keflex (a medications caused by bacteria) is times a day, for 10 day amove all materials that red impede healing) the awater, cover with a sterind follow up in the clinic had no improvement. I'M, nurse's note indicate inseparatitioner the resident's burn from 6 AM rs) I'M, nurse's note indicate inseparatitioner the resident's dressing to the and the area was mostly ster in the center of the note indicated the nurse reline gauze to the burn, that telfa dressing, and gwith mefix fabric tape. I'm dicated an aide reported that it is indicated an aide reported that it is indicated an aide reported that it is revealed no documentate.	d the fin 5000 s, may rea, lee in 3 r an until d the dent d the flex. ed the burn y	F 157		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175295		B. WING		06/11	
	OVIDER OR SUPPLIER HEALTH AND REHA	AB AT SMITH CENTER	117 W 1	ESS, CITY, STA ST ST #369 ENTER, KS)		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY F R LSC IDENTIFYING INFORMAT	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 157	The 5/10/14 at 1:19 the burn area on the bright red and white note indicated when wound and a little bit tissue separating from the nurse applied a dressing, and secure tape. The 5/11/14 at 12:04 the staff faxed the number about continuing the area twice a day. The 5/13/14 at 10:10 the nurse received a practitioner to change the burn area on his medication used to practitioner to change the burn area on his medication used to practitioner to change the burn area on his medication used to practitioner to change the burn on the residence of the burn on the residence of the burn on the residence of the incident, room. Observation of the incident, room.	PM, nurse's note indicate resident's right arm had areas and no drainage. The nurse cleansed the tof the white slough (death living tissue) came off sterile Vaseline gauze, and the dressing with meform the dressing with meform the nurse practitioner to inquire current treatment to the correct minor infections and order from the nurse gethe resident's treatment for the correct minor infections are with a dressing until the plant of	The ad f, and telfa ix ated re burn ated nt to sin (a ce a ed ad th a en the had ssue, the at the ent ice	F 157			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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DESERET	HEALTH AND REH	AB AT SMITH CENTER		ST ST #369 CENTER, KS			
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F 157	a wooden device, w bottom, that stood a the floor and was ap Further observation inches from the top strip, approximately wide, where the air of The product information woutput of room tempsafety information wood of 3/14 at 9:29 Al Administrative Nurse device, and with the through the metal st temperature of the metal strip was 189. On 6/3/14 at 10:48 Al Nurse B illustrated metal strip was 189. On 6/3/14 at 10:48 Al Nurse B illustrated metal metal strip the resident explained the staff puther ight side of the towards the resident inches from the recliner with device. On 6/2/14 at 11:00 Al resident had a spacelong time prior to the verified the resident	ith 4 rolling wheels on the pproximately 18 inches to proximately 14 inches we revealed approximately of the wooden device at 12 inches long and 2 inches long and 3 inches lo	from vide. 2 metal ches ce. d an s. No g g s at tive flow he d e ed the B e on elly 4 ed e right for a d	F 157			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVABLE COMPLETED	
175295 B. WING CO 06/11/	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
DESERET HEALTH AND REHAB AT SMITH CENTER 117 W 1ST ST #369 SMITH CENTER, KS 66967	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157 Continued From page 6 F stated he/she moved the heating device away from the resident when it was too close. On 6/2/14 at 1:30 PM, Administrative Nurse A stated he/she called the corporative office and they reported the facility was not to have a space heater in the building. Administrative Nurse A stated the facility did not have a policy for space heaters but the administrator was making a policy at this time. On 6/2/14 at 4:00 PM, Nurse Aide C stated the resident had a heating device in his/her room and he/she frequently moved it closer to him/her by pulling on the cord of the heating device when seated in his/her recliner. On 6/3/14 at 8:06 AM, Maintenance Staff D stated the resident had the heating device for a long time and stated the device was not supposed to get hot on the surface but the metal strip would get hot. On 6/3/14 at 9:20 AM, Administrative Nurse A stated the resident moved the heating device closer to himself/herself and the heating device should never have been in his/her room. Administrative Nurse A stated the staff should have notified the physician when the burn on the resident was first discovered. On 6/3/14 at 10:14 AM, Nurse Aide E reported the resident moved the heating device closer to him/her by placing his/her hands on the heating device, and rolling it towards him/herself. On 6/11/14 at 12:00 PM, Medical Staff G stated the resident had some dementia that decreased his/her cognition. Medical Staff C stated when the burn was first reported to him/her, staff gave the	

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		175295		B. WING		06/11/2	014
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRE	ESS, CITY, STA	TE, ZIP CODE		
DESERET	HEALTH AND REHA	AB AT SMITH CENTER		ST ST #369 ENTER, KS			
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F 157	heating device and rehis/her upper right ar stated the staff did not he/she was in the fact he/she did not see the The 6/2013 facility but apply cold to a bur extremity in ice water towels, cover the bur any clean cloth, decr from contacting the in the physician and follows.	ent brushed up against eceived a small burn to rm. Medical Staff G furth of mention the burn whe cility making rounds, so ne burn. urn policy instructed the rn, immerse affected or for 10 minutes, apply or with a sterile dressing rease pain by preventing njured surface and to no low orders.	estaff cool g or g air otify	F 157			
	Policy instructed the about the resident's policy instructed the the physician's answ response is too long, the physician. The facility failed to pwhen Resident #1 accuper arm below the 483.20(d)(3), 483.10 PARTICIPATE PLANThe resident has the incompetent or other incapacitated under the participate in plannin changes in care and A comprehensive call.	(k)(2) RIGHT TO NNING CARE-REVISE (right, unless adjudged wise found to be the laws of the State, to g care and treatment or treatment. re plan must be develop	cian ie e on id if II to ician r right	F 280			
	within 7 days after th						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		175295		B. WING		06/11/2	2014
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DESERET	HEALTH AND REHA	AB AT SMITH CENTER		ST ST #369 ENTER, KS	66967		
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F 280	interdisciplinary team physician, a register for the resident, and disciplines as determ and, to the extent pro the resident, the resi legal representative;	ge 8 n, that includes the attered nurse with responsibility other appropriate staff in hined by the resident's nacticable, the participatic dent's family or the resident's family or the resident and periodically reviewed m of qualified persons a	ility n eeds, on of dent's	F 280			
	This Requirement is not met as evidenced by: The facility had a census of 26 residents. The sample included 3 residents. Based on observation, record review and interview the facility failed to evaluate and revise the care plan regarding a space heater for 1 of 3 sampled residents.(#1)						
	5/1/14-5/30/14, indice diagnoses of cellulities with and tissues benopen wound on his/r (inflammation of the (a painless eye conception of the retination of vision) and vasculatescribing problems	gned physician orders, deated the resident had so (a bacterial infection of eath the skins) on the least buttock, dermatitis skin), macular degeneral dition in which the central deteriorates and causes ar dementia (a general to with reasoning, planning and other thought process	f the eg, an ation al lack erm g,				
	caused by brain dam flow to your brain). The 4/23/14 quarterl 3.0 assessment indice	nage from impaired bloo y (MDS) Minimum Data cted the resident require with (ADLs) Activities of	Set				

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F 280	Daily Living and had cognition with a (BIM Status score of 8. The had impairment on his side and impairment lower extremities. The 4/23/14 care plaquestion unrealistic of to ensure the resider related to poor decisiterm memory. The cate of the memory is the memory of	moderately impaired IS) Brief Interview for Manager Interview for Manager Interview for Manager Interview for Manager Interview on both sides of his/her and instructed the staff to be or dangerous decisions and the would not experience in making and poor share plan instructed the staff to provide assistance and to provide assistance and to ileting. Review of the original manager in the provide in the resident's room due to he cold. Decord for the resident good in the provide in th	and injury ort ttaff of 1-2 ne al is/her on in ter nd n n"	F 280			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	E CONSTRUCTION	(X3) DATE SUR COMPLETE	ED
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	aide had reported to the red blistered area to the red blistered area to the purchase assessed the red broken blister over the long by 3 cm wide. The resident had a person his/her recliner and the from his/her room. The 5/4/14 at 10:27 At the nurse notified the department of the reside reported the department of the reside reported the the aide reported the department of the reside reported the The 5/4/14 at 10:31 At the wound on the back measured 9 cm long lin size from 6 cm to 9. The 5/4/14 at 1:30 PM nurse received an order practitioner to administrate used to treat infection (mg) milligram, three and to debride (to report and to debride (to report and to debride) and wash with soap and we vaseline dressing, and or 4 days if the area had revention to the resident to	M, nurse's note indicate the nurse the resident he back of his/her right. The note indicated the resident and the area had red area measuring one note indicated the half heater a few inches he nurse removed the half heater a few inches he nurse removed the half heater a few inches he nurse removed the half hospital emergency ident's burn. (4 hours a resident's burn to the nurse indicate the few inches half hospital emergency ident's burn to the nurse indicate the few inches half hospital emergency ident's right by 3 cm wide. (an increased hospital emergency ident's right by 3 cm wide. (an increased ler from the nurse ster Keflex (a medicated is caused by bacteria) the few inches a day, for 10 day nove all materials that red in impede healing) the a water, cover with a sterification of improvement. If record revealed no aff provided first aide, continued in the	and a arm and a arm and a arm and a arm and a a arm and a a arm and a arm from eater ed after urse) ed arm ase d the an 500 s, may rea, le in 3	F 280			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		175295		B. WING		C 06/11/2014	
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DESERE1	HEALTH AND REHA	AB AT SMITH CENTER		ST ST #369 ENTER, KS			
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F 280	nurse practitioner ca The 5/4/14 at 8:25 F nurse changed the re above his/her elbow debrided, with a blist The nurse's note ind sterile Vaseline gauz area with a telfa dres dressing with mefix f further indicated an a resident's right arm v 5/3/14. The medical record r nurse assessed the The 5/10/14 at 1:19 the burn area on the bright red and white note indicated when wound and a little bit tissue separating fro the nurse applied a s dressing, and secure tape. The 5/11/14 at 12:04 the staff faxed the nu about continuing the area twice a day. The 5/13/14 at 10:10 the nurse received a practitioner to chang the burn area on his medication used to p caused by small cuts	PM, nurse's note indicate esident's dressing to the and the area was mostly ter in the center of the wicated the nurse applied to the burn, covered the sing, and secured the fabric tape. The nurse's laide reported the area of was present at bedtime of the revealed no documentate.	ed the burn y ound. I a he note in the on ion a led I The led ix telfa ix ted re burn ted in to cin (a	F 280			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
7.1.2.1.2.1.10.	0011112011011					33 22	C	
		175295		B. WING		06/1	1/2014	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
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F 280	Continued From pag	e 12		F 280				
	burn on the resident's round open areas, 1 of center and the skin so was pink.	PM nurse's note indicate right upper arm had two cm in diameter, with a warrounding the open are	vo, vhite ea					
	On 6/2/14 at 4:10 PM, observation revealed the resident's right upper arm, above the elbow, had 2 small raised pea size white areas of scar tissue, surrounded by slightly pink tissue.							
	facility's space heater time of the incident, s room. Observation re was a Sunbeam mod a wooden device, with bottom, that stood ap the floor and was app Further observation re inches from the top of strip, approximately 1 wide, where the air fl The product informatio output of room tempe safety information was		at the lent lice liside e from lide. 2 metal ches lice. d an					
	Administrative Nurse device, and with the of through the metal stritemperature of the metal stritemperature of the metal strice on). Observation Nurse A turned off the through the metal stritemetal strip was 189.7	I, observation revealed A turned on the heating device on and air flowin p, he/she obtained the etal strip at 195 degree fter turning the heating on revealed Administrate heating device, no air p, the temperature of the M, observation revealed	g s at ative flow					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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DESERET	HEALTH AND REHA	B AT SMITH CENTER		ST ST #369			
			SMITH	ENTER, KS	6 66967		
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F 280	Nurse B illustrated horecliner and where the heating device. Obseseated in the resident explained the staff plather right side of the retowards the resident's inches from the reclin Nurse B illustrated the in his/her recliner who device. On 6/2/14 at 11:00 Al resident had a space long time prior to the verified the resident who was the heating deverous from the resident who was the heaten that they reported the facility did the heater in the building stated the facility did the heaters but the admirat this time. On 6/2/14 at 4:00 PM resident had a heating he/she frequently morpulling on the cord of seated in his/her recliner.	ow the resident sat in the staff usually positioner revealed Nurse It's recliner, and he/she aced the heating device ecliner, with the air flow is right side, approximater. Observation revealed resident leaned to the en sleeping toward the en sleeping toward the heater in his/ her room burn incident. Nurse Fivas confused and would rice closer to him/her. Need the heating device are it was too close. I Administrative Nurse And the corporative office are lity was not to have a sen it was not to have a sen it was root to have a sen it was making a policy for sponistrator was making a policy for sponistrator was making a gold device in his/her roon wed it closer to him/her the heating device where the stag device where	ed the B e on ely 4 ed et right for a d lurse way A nd pace A lace policy the n and by en	F 280	DEFICIENCY)		
	long time and stated to supposed to get hot of strip would get hot.	the device was not on the surface but the m	netal				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SUF	
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		B AT SMITH CENTER	117 W 1	ST ST #369	•		
			SMITH C	ENTER, KS	6 66967		
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F 280	Continued From pag	e 14		F 280			
	On 6/3/14 at 9:20 AM stated the resident me closer to himself/hers should never have be On 6/3/14 at 10:14 AI the resident moved the him/her by placing his device, and rolling it to On 6/11/14 at 12:00 Fithe resident had some his/her cognition. Mean burn was first reporte impression the resident	I, Administrative Nurse oved the heating device elf and the heating device elf and the heating device en in his/her room. M, Nurse Aide E reporte he heating device close s/her hands on the heat owards him/herself. PM, Medical Staff G state dementia that decrea dical Staff G stated whe d to him/her, staff gave ent brushed up against a	ed r to ting ted sed en the the				
	heating device and received a small burn to his/her upper right arm. Medical Staff G further stated the staff did not mention the burn when he/she was in the facility making rounds, so he/she did not see the burn.		en				
	verified no documenta staff regarding the sp room on the care plar		he ent's				
	to apply cold to the buextremity in ice water towels, cover burn witclean cloth, do decrea	arn policy instructed the urn, immerse affected for 10 minutes, apply of the a sterile dressing or asse pain by preventing a jured surface and to no orders.	cool any air				
	=	6/13 Care Interdisciplinary Policy develop a comprehens	iive				

Printed: 06/11/2014 FORM APPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED 175295 B. WING 06/11/2014 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER DESERET HEALTH AND REHAB AT SMITH CENTER 117 W 1ST ST #369 SMITH CENTER, KS 66967 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 280 F 280 Continued From page 15 care plan within 7 days of completion of the resident's assessment. The policy instructed the interdisciplinary team to review and revise the care plan after each resident assessment or assessment review. The facility failed to evaluate and revise Resident #1's care plan regarding the space heater, in the resident's room. F 323 483.25(h) FREE OF ACCIDENT F 323 HAZARDS/SUPERVISION/DEVICES SS=G The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by: The facility had a census of 26 residents. The sample included 3 residents. Based on observation, record review and interview the facility failed to provide an environment that was free from accident hazards for 1 of 3 sampled residents reviewed for accidents who sustained a burn from a space heater.(#1) Findings included: - Resident #1 's signed physician orders, dated 5/1/14-5/30/14, indicated the resident had diagnoses of cellulitis (a bacterial infection of the skin and tissues beneath the skins) on the leg, an open wound on his/her buttock, dermatitis (inflammation of the skin), macular degeneration (a painless eye condition in which the central portion of the retina deteriorates and causes lack

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F 323	of vision) and vascular describing problems in judgment, memory and caused by brain damflow to your brain). The 4/23/14 quarterly 3.0 assessment indicextensive assistance Daily Living and had cognition with a (BIM Status score of 8. The had impairment on his side and impairment lower extremities. The 4/23/14 care plant question unrealistic of to ensure the resident related to poor decisiterm memory. The catton monitor independed unsafe practices, and staff with transfers are care plan revealed not space heater in the recomplaints of being of the weekly wound recomplaints of the w	ar dementia (a general to with reasoning, planning and other thought process age from impaired blood of (MDS) Minimum Data stated the resident require with (ADLs) Activities of moderately impaired S) Brief Interview for Mee MDS indicated the resis/her upper extremity of on both sides of his/her in instructed the staff to or dangerous decisions and would not experience from making and poor should be active transfers and report of the provide assistance of the distriction of an electrical esident's room due to his cold.	g, ses d Set ed of ental sident n one ental sident and injury port taff of 1-2 ne al is/her ental sis/her	F 323			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	•	
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F 323	Continued From page	e 17		F 323			
	that remained the sar	ne size as above.					
	On 5/16/14 the resident had a burn area to the back of his/her right arm above his/her elbow with 2 small, 1 cm, open areas with pink skin surrounding the open areas.						
	On 5/23/14 the burn area was healed. (19 days after acquiring the burn)						
	The 5/4/14 at 6:00 AM, nurse's note indicated an aide had reported to the nurse the resident had a red blistered area to the back of his/her right arm just above the elbow. The note indicated the nurse assessed the resident and the area had a broken blister over the red area measuring 6 cm long by 3 cm wide. The note indicated the resident had a personal heater a few inches from his/her recliner and the nurse removed the heater from his/her room.						
	the nurse notified the department of the res	M, nurse's note indicat hospital emergency ident's burn. (4 hours a resident's burn to the n	ıfter				
	The 5/4/14 at 10:31 AM, nurse's note indicated the wound on the back of the resident's right arm measured 9 cm long by 3 cm wide. (an increase in size from 6 cm to 9 cm long.)		arm				
	nurse received an ord practitioner to adminis used to treat infection (mg) milligram, three and to debride (to ren promote infection and wash with soap and w	M, nurse's note indicated for from the nurse ster Keflex (a medication is caused by bacteria) times a day, for 10 day nove all materials that red impede healing) the a water, cover with a sterial follow up in the clinic	on 500 s, nay rea, le				

` '		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
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F 323	Continued From page	e 18		F 323			
	or 4 days if the area h	nad no improvement.					
	Review of the medical record revealed no documentation the staff provided first aide, or and intervention to the resident's burn from 6 AM until 1:30 PM. (7 1/2 hours)						
	The 5/4/14 at 1:54PM, nurse's note indicated the nurse notified the nurse practitioner the resident already received Zithromax (an antibiotic) and the nurse practitioner cancelled the order for Keflex.						
	nurse practitioner cancelled the order for Keflex. The 5/4/14 at 8:25 PM, nurse's note indicated the nurse changed the resident's dressing to the burn above his/her elbow and the area was mostly debrided, with a blister in the center of the wound. The nurse's note indicated the nurse applied a sterile Vaseline gauze to the burn, covered the area with a telfa dressing, and secured the dressing with mefix fabric tape. The nurse's note further indicated an aide reported the area on the resident's right arm was present at bedtime on 5/3/14.		burn y ound. a he note n the				
	The medical record renurse assessed the a	evealed no documentat rea on 5/3/14.	ion a				
	the burn area on the rebright red and white a note indicated when to wound and a little bit tissue separating from the nurse applied a st	PM, nurse's note indicate resident's right arm had areas and no drainage. The nurse cleansed the of the white slough (dean living tissue) came off terile Vaseline gauze, and the dressing with meforesident's right arms.	The ad ; and telfa				
	the staff faxed the nur	PM nurse's note indicarse practitioner to inquir	re				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 323	area twice a day. The 5/13/14 at 10:1 the nurse received practitioner to chan the burn area on his medication used to caused by small cu day and cover the a healed. The 5/15/14 at 8:55 burn on the resident round open areas, center and the skin was pink. On 6/2/14 at 4:10 Fresident's right uppr 2 small raised peasurrounded by slight On 6/3/14 at 8:07 Afacility's space healtime of the incident room. Observation was a Sunbeam modera wooden device, whottom, that stood at the floor and was a Further observation inches from the top strip, approximately wide, where the air The product information was afety inform	10 AM nurse's note indicate an order from the nurse age the resident's treatmer s/her right arm to bacitrace prevent minor infections ats, scrapes, or burns) twice area with a dressing until a PM nurse's note indicate at's right upper arm had two 1 cm in diameter, with a wearrounding the open are PM, observation revealed for arm, above the elbow, size white areas of scar time of the pink tissue. AM, observation revealed for the resident at, stored in an empty reside revealed the heating deviced SH 1500 enclosed in with 4 rolling wheels on the approximately 14 inches we have revealed approximately 2 of the wooden device a revealed approximately 2 of the wooden device a region indicated it produced perature plus 120 degrees	ed the //o, white ea the had ssue, the eat the ent cce side e from ide. 2 metal ches ce. d an	F 323		
	Administrative Nurs	se A turned on the heating	9			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 323	Continued From pag	e 20		F 323			
F 323	device, and with the of through the metal strip temperature of the megistropy of the metal strip was 189.7 On 6/3/14 at 10:48 Al Nurse B illustrated her recliner and where the heating device. Obsein the resident's reclir the staff placed the heside of the recliner, we resident's right side, at the recliner. Observatillustrated the resident his/her recliner when On 6/2/14 at 11:00 Al resident had a space long time prior to the verified the resident whose from the resident when On 6/2/14 at 1:30 PM stated he/she called the they reported the facility did stated the facility did	device on and air flowin p, he/she obtained the etal strip at 195 degrees fter turning the heating ion revealed Administrate heating device, no air p, the temperature of the control of the control of the staff usually positioned and the etal of the staff usually positioned are and he/she explained etal of the explained etal of t	s at tive flow ne d e e d the B sat ed ht the from vice. for a d lurse way	F 323			
	On 6/2/14 at 4:00 PM resident had a heatin	I, Nurse Aide C stated t g device in his/her roon ved it closer to him/her	n and				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 323	pulling on the cord of seated in his/her recl On 6/3/14 at 8:06 AN stated the resident his long time and stated supposed to get hot strip would get hot. On 6/3/14 at 9:20 AN stated the resident moles to himself/hers should never have be on 6/3/14 at 10:14 A the resident moved thim/her by placing his device, and rolling it on 6/11/14 at 12:00 the resident had som his/her cognition. Me burn was first reporte impression the resident heating device and rolling device and rolling device and rolling he/she was in the fact he/she did not see the The 6/2013 facility be to apply cold to the be extremity in ice water towels, cover the burn any clean cloth, do dair from contacting the notify the physician at The facility failed to part of the fa	f the heating device whe liner. A, Maintenance Staff D ad the heating device for the device was not on the surface but the notation device device the heating device self and the heating device en in his/her room. AM, Nurse Aide E reports he heating device close is/her hands on the heat towards him/herself. PM, Medical Staff G stated where the device of the state of the st	anetal A e rice ed r to ting ated ased en the ethe a en en staff cool g or ting that	F 323		

			A. BUILDING		(X3) DATE SURVEY COMPLETED	
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avoidable burn by a s	space heater to cognitiv		F 323			
	OVIDER OR SUPPLIER SUMMARY S (EACH DEFICIENT REGULATORY OF COntinued From page avoidable burn by a second continued from page avoidable for the first factor factor from page avoidable for the first factor	THEALTH AND REHAB AT SMITH CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT Continued From page 22 avoidable burn by a space heater to cognitive	OVIDER OR SUPPLIER THEALTH AND REHAB AT SMITH CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	THEALTH AND REHAB AT SMITH CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 avoidable burn by a space heater to cognitively	THEALTH AND REHAB AT SMITH CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 117 W 1ST ST #369 SMITH CENTER, KS 66967 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 avoidable burn by a space heater to cognitively	THEALTH AND REHAB AT SMITH CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 avoidable burn by a space heater to cognitively A. BUILDING COMPLETE COMPLETE (EACH CORPCTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) FROM DATE SON COMPLETE COMPLETE